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Communication Prompts Donation: Exploring the Beliefs Underlying Registration and  
Discussion of the Organ Donation Decision

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## Abstract

*Objectives:* To use a Theory of Planned Behaviour (TPB) framework to explore the beliefs underlying communication of the donation decision for people who had not previously registered their consent on a donor register or discussed their decision with significant others.

*Design:* Initially, a focus group study elicited the common TPB (behavioural, normative, control) beliefs about registering and discussing the organ donation decision. The main study assessed the important TPB belief predictors of intentions to register and discuss the donation decision.

*Method:* University students and community members from Queensland, Australia ( $N = 123$ ) completed items assessing their intentions and the TPB behavioural, normative, and control beliefs for registering and discussing their donation decision.

*Results:* Structural Equation Modelling analyses revealed significant paths between people's intentions to register their donation decisions and underlying behavioural (e.g. enabling efficient donation procedures), normative (e.g. friends, doctors/medical professionals), and control (e.g. lack of motivation, knowing details about transplant recipients) beliefs ( $R^2 = .30$ ). There were also significant paths between people's intentions to discuss their donation decision and underlying behavioural (e.g. feeling uncomfortable talking about death related topics) and normative (e.g. partner/spouse, family members) beliefs, but not control beliefs ( $R^2 = .33$ ). There was a significant path between intentions to register and intentions to discuss one's donation decision.

*Conclusions:* Results highlight the importance of focussing on behavioural and normative beliefs about communicating the donation decision, specifically for people who have not previously communicated their decision, and suggest potential targets for interventions designed to promote decision communication.

## Communication Prompts Donation: Exploring the Beliefs Underlying Registration and Discussion of the Organ Donation Decision.

The crucial steps to increase the low rates of organ donors in many Western countries include ensuring, first, that potential donors are identified and, second, that authority is sought and obtained from family members of the potential donor before organ procurement can occur (DeJong et al., 1998; Gortmaker et al., 1996; West & Burr, 2002). Many studies have identified family consent as the critical link in ensuring organ supply meets the increasing demand for transplantable organs (DeJong et al., 1998; Sque & Payne, 2006). Approximately half of the families approached for organ donation deny consent, a pattern which is consistent in the United Kingdom (41%), United States (54%), and Australia (50%) (Barber, Falvey, Hamilton, Collett, & Rudge, 2006; Mathew, 2004; Sheehy et al., 2003). One aspect thought to play a central role in improving the likelihood of obtaining consent is family members' prior knowledge of their loved one's intentions to donate their organs upon death (Siminoff, Gordon, Hewlett, & Arnold, 2001). Family members who are aware of an individual's positive attitudes to donation and have previously discussed donation are more likely to fulfil the wishes of their family member by giving consent (Dejong et al., 1998; Gortmaker et al., 1996; West & Burr, 2002).

There are many ways to express donation intentions including signing a donor card, registering on a donor register or stating preferences on a driver licence. It is becoming increasingly clear, however, that, regardless of the method by which an individual has recorded their intentions, they also need to communicate their wishes to their family members or next-of-kin, a behaviour which many individuals have not undertaken (Breitkopf, 2006; McDonald et al., 2007; Radecki & Jaccard, 1997). Previous research has identified the attitudes and beliefs impacting upon willingness to donate organs in general (see Radecki & Jaccard, 1997 for a review). Comparatively fewer studies, however, have investigated the reasons why individuals

fail to communicate their donation decision (Afifi et al., 2006; Breitkopf, 2006; McDonald et al., 2007). Thus, in the current study, we focus our attention specifically on those individuals who have not previously communicated their organ donation decision by recording it on a donor register or by discussing it with a partner or family members.

Reasons for not recording donation wishes identified in previous studies include a perceived family objection or lack of support for donation, distrust of the medical system, avoidance of bodily mutilation and premature death, having to defend one's decision to family, and lack of knowledge or being uncertain about the donation process (e.g., Brug, van Vugt, van den Borne, Brouwers, & van Hooff, 2000; Kopfman & Smith, 1996; Morgan & Miller, 2002; Radecki & Jaccard, 1999). Negative beliefs about discussing donation wishes include the perceived reluctance or objection of family members to talk, a lack of knowledge about organ donation, having to defend the donation decision to family, difficulty starting the conversation, and talking about the death of one's self and important others (Breitkopf, 2006; Hyde & White, 2007; Morgan, 2004; Vincent, 2006; Thompson, Robinson, & Kenny, 2004; Waldrop, Tamburlin, Thompson, & Simon, 2004).

While these studies provide important information about the decision to communicate donation wishes, many studies provide only separate examinations of signing/registering (e.g., Brug et al., 2000; Kopfman & Smith, 1996; Morgan & Miller, 2002) or discussing the donation decision with significant others (e.g., Morgan, 2004; Vincent, 2006; Waldrop et al., 2004) and rarely consider the beliefs underlying both behaviours in the same sample (c.f. Hyde & White, 2007). A simultaneous consideration of the beliefs underlying registering and discussing behaviour allows us to determine if there are common key belief sets that may be targeted to create future, cost-effective interventions and campaigns or if separate interventions and campaigns need to be designed to encourage the two key communication steps of one's decision.

In addition, several studies (e.g., Morgan & Miller, 2001; Morgan, Miller, & Arasaratnam, 2003; Guadagnoli et al., 1999) include participants who have already partially communicated their decision in some way (e.g., having signed a donor card) and, as such, these studies may reflect the decision to maintain or repeat communication behaviours rather than to initiate communication of one's decision. Consequently, the beliefs about registering and discussing organ donation wishes for the specific population of people who have not communicated their decision previously warrant explicit examination.

To facilitate an exploration of these beliefs, we used a well known decision making framework, the Theory of Planned Behaviour (TPB; Ajzen, 1991). According to the TPB (Ajzen, 1991), intentions are the most proximal determinant of behaviour. Intentions are influenced by three constructs: attitudes (positive or negative evaluation of the behaviour); subjective norm (perceptions of important others about behavioural performance); and perceived behavioural control (perceived control over behavioural performance). To understand the determinants of these three constructs influencing intentions, the TPB proposes an examination of the beliefs that underlie them. Attitudes are considered to be influenced by behavioural beliefs, the outcomes associated with the behaviour (advantages and disadvantages), weighted by the positive or negative evaluation of these outcomes. Subjective norms are said to be determined by the perceived expectations of specific individuals or groups (normative beliefs) weighted by the individual's motivation to comply with these expectations. Perceived behavioural control is determined by the likelihood that different factors may interfere with (i.e., barriers) or facilitate (i.e., motivators) performance of a behaviour (control beliefs) weighted by the perceived impact these factors would have on behavioural performance. The belief basis of the TPB has previously been used to understand the beliefs underlying a variety of behaviours, including organ donation

(Hyde & White, 2007), as well as those behaviours with an altruistic basis such as blood donation (Armitage & Conner, 2001) and volunteering (Greenslade & White, 2002).

### *The Current Study*

The current study used a TPB belief-based framework to facilitate an understanding of the beliefs influencing the choice to communicate the organ donation decision in a sample of respondents who had not previously communicated their donation decision. We chose two target behaviours crucial to the communication of the donation decision: *registering*, defined as “registering your consent to donate your organs upon death via the Australian Organ Donor Register”, and *discussing*, defined as “discussing your decision to donate (or not donate) your organs upon death with your partner or family members”. An elicitation study using content analysis allowed an initial identification of the modal salient behavioural, normative, and control beliefs underlying the two behaviours of registering and discussing the donation decision in the population of interest. Findings from the elicitation study informed the development of the main study which allowed an assessment of the important belief predictors of intentions to register and discuss the donation decision.

## Method

### *Participants and Procedure*

Participants for the main study were drawn from a larger sample of 479 respondents comprising both students ( $n = 285$ ) and community members ( $n = 194$ ), completing a questionnaire about organ donation. For analyses in the current study, we focussed specifically on the sub-sample of respondents who had not previously registered and had not previously discussed their donation decision ( $N = 123$ ; 109 students, 14 community members). Participants (44 males, 79 females), ranged in age from 17 to 76 years ( $M = 24.66$  years;  $SD = 12.96$  years). Most participants self identified as Caucasian (73%). Approval to conduct the study was granted

from the University Human Research Ethics Committee. Students were recruited from a large metropolitan university in South East Queensland, Australia via in-class announcements and received course credit and the opportunity to win one of four AUD\$30 music vouchers.

Community participants were recruited via letter box drops in various areas in South East Queensland, Australia and were given the opportunity to win one of four AUD\$50 department store vouchers. Participants completed questionnaire items assessing the belief-based TPB measures (as specified by Ajzen, 1991) relevant to each behaviour and their intention to register and discuss their donation decision.

### *Elicitation Study*

In line with the TPB belief-based framework (Ajzen, 1991, 2006), we conducted an elicitation study to identify the modal salient behavioural, normative, and control beliefs about registering and discussing one's organ donation decision for the population under study (Ajzen & Fishbein, 1980). A total of 24 (8 males, 16 females; Age  $M = 26.00$  years;  $SD = 8.54$  years, range = 17 to 48 years), primarily Caucasian (92%), students from a large metropolitan university in South East Queensland, Australia ( $n = 19$ ) and community members from a local health clinic in the same region ( $n = 5$ ) participated in one of five focus group discussions conducted with participants who were in attendance at the time of the focus group.<sup>1</sup> Students received course credit for their participation and community participants were compensated AUD\$10 for their time.<sup>2</sup> Approval to conduct the study was granted from the University Human Research Ethics Committee. Using content analysis, we elicited the most frequently occurring *behavioural* (advantages and disadvantages; e.g., enabling efficient procedures to assist in the donation process, creating distress or conflict if family members disagree with their decision), *normative* (important referents approving or disapproving; e.g., partner/spouse, family members), and *control* (barriers and motivators; e.g., lack of motivation, knowing details about people who had



benefited from a transplant) beliefs for each behaviour. Given the small sample size, beliefs raised 3 times or more (i.e., 15% of responses) on separate occasions by different participants were included in analyses.

### *Main Study*

*Intention measures.* Two items for each behaviour assessed the strength of intention to register and discuss the decision. The two items were: “It is likely that I will register my consent to donate my organs upon death (discuss my donation decision with my partner or family members)” and “I intend to register my consent to donate my organs upon death (discuss my donation decision with my partner or family member), both scored 1 (*strongly disagree*) to 7 (*strongly agree*). The two items for each behaviour were summed to create intention scales which were significantly correlated at  $p < .001$  (Registering:  $r = .80$ ; Discussing:  $r = .75$ ).

*Belief measures.* All belief items were rated on scales from 1 (*extremely unlikely*) to 7 (*extremely likely*). Although traditionally assessed by a multiplicative combination of belief (i.e., behavioural, normative, and control beliefs) and evaluative items (i.e., outcome evaluations, motivation to comply, and perceived power), the main study questionnaire only assessed the belief items due to the argument that the evaluative items are not essential for belief measurement (Ajzen, 1991) and given the space constraints in the questionnaire. All belief scales were reliable with Cronbach’s alphas above .70 with the exception of behavioural beliefs for registering which had a Cronbach’s alpha of .62.<sup>3</sup> Behavioural, normative and control beliefs were assessed separately for each behaviour of registering and discussing.

For *registering behavioural beliefs*, participants rated how likely three disadvantages (receiving inadequate medical care to hasten the transplantation process, being unable to change my mind if I die prematurely, creating distress for my family if they disagree with my decision) and two advantages (saving others from having to make the decision for me, enabling efficient

procedures to assist in the donation process) were to occur if they registered their decision.

Participants' ratings of the likelihood that three disadvantages (creating conflict if my partner/family members disagree with my decision, feeling pressure to change my mind, feeling uncomfortable talking about death related topics) and three advantages (making those who are close to me aware of my decision, gaining approval from my partner/family members for my donation decision, being aware of my partner/family member's organ donation decision/s) would occur if they discussed their decision comprised the measure of *discussing behavioural beliefs*.

To create the separate behavioural belief scales for each of the behaviours, the disadvantages related to the specific behaviour were reverse scored such that high scores reflected the likelihood that the belief would not occur. Scores for the disadvantages and advantages for the specific behaviour were then summed and averaged to create a separate behavioural belief scale for registering and discussing.

For *registering normative beliefs*, participants rated the likelihood that seven specific referents (spouse/partner, family members, friends, doctors and other medical professionals, religious groups/people, transplant recipients, government organisations) would approve of them registering and for *discussing normative beliefs*, six specific referents (spouse/partner, family members, friends, doctors and other medical professionals, religious groups/people, government organisations) would approve of them discussing their decision. Normative belief scores for each behaviour were summed and then averaged to create each normative belief scale.

For *registering control beliefs*, respondents rated the likelihood that four barriers (lack of knowledge about how to register, lack of motivation to register, lack of knowledge about the process of organ donation, being unsure about my donation decision) and four motivators (information about how to register, the media, knowledge of who organs go to [e.g., health status, history, demographic details of recipient], knowledge about the process of organ donation) would

prevent and encourage them, respectively, to register their donation decision. For *discussing control beliefs*, respondents considered the likelihood six barriers (uncertainty about when to raise the topic, lack of motivation to discuss my decision, uncertainty about how to raise the topic, being unsure about my donation decision, lack of knowledge about the process of organ donation, being unable to justify my decision to my partner/family members) would prevent them and four motivators (information or ideas about how to tell your partner or family members about your donation decision, the media, knowledge about the process of organ donation, information or ideas about when to tell your partner or family members about your donation decision) would encourage them to discuss their decision. To create the separate control belief scales for each behaviour, the motivators related to the specific behaviour were reverse scored. Scores for the barriers and motivators for the specific behaviour were then summed and averaged to create a separate control belief scale for registering and discussing. As such, high scores on the control belief scales reflected the likelihood that the motivator would not encourage the respondents to perform the behaviour and the likelihood that the barrier would prevent the respondent from performing the behaviour.

## Results

### *Statistical analysis*

For the purposes of analyses using Structural Equation Modelling (SEM) which prohibits the presence of missing data, cases with missing values were removed leaving a total sample size of 107 cases.<sup>4</sup> Initially, the relationships between the measured variables and intentions for the two target behaviours of registering the donation decision and discussing the donation decision were examined using bivariate correlations. Structural equation modelling was then performed using AMOS 6.0. The fit of the models was determined by a number of indicators. A satisfactory fit is obtained when the chi-squared test is non-significant but is also acceptable if the chi-square

statistic is not more than three times the degrees of freedom (Kline, 2005). Maximum likelihood was used to estimate the parameters of the models. Due to the dependence of chi-square tests on sample size and the number of variables included in the model, other indices were also examined. The fit of the models were also evaluated with the Comparative Fit Index (CFI), the Tucker-Lewis Index (TLI) and the Root Mean Square Error of Approximation (RMSEA). A moderate fit is obtained when the CFI and TLI are above .90 and the RMSEA is below .08 (Marsh, Balla, & Hau, 1996). Given that fit indices are often affected by small sample sizes (Hu & Bentler, 1995), and that the TLI is not recommended for use with sample sizes below 150 (Hoyle & Panter, 1995), we also examined the Incremental Fit Index (IFI; Bollen, 1989) as it is less variable in small sample sizes (Hoyle & Panter, 1995). An IFI close to a value of 1 indicates a very good fit (Bollen, 1989). Path coefficients and  $R^2$  values were also inspected to evaluate the predictive power of the model. The scales produced adequate reliabilities above .70 (with the exception of registering behavioural beliefs which had an alpha reliability of .62); therefore, only scale scores were entered into the structural model.

*Correlations amongst the TPB beliefs and Intention for Each Behaviour of Registering and Discussing*

Table 1 presents the means, standard deviations, and correlations between the TPB beliefs and intention for the two behaviours of registering the donation decision and discussing the donation decision. For registering, the TPB belief predictors related to registering and intentions to register were all significantly inter-correlated, with a negative correlation between control beliefs for registering and the other variables for registering emerging as expected ( $r_s = -.20$  to  $.49$ ). Behavioural beliefs for registering were the strongest correlate of intentions to register ( $r = .49$ ). For discussing, the TPB belief predictors related to discussing and discussing intentions were significantly inter-correlated, with a negative correlation between control beliefs for

discussing and some variables for discussing emerging as expected ( $r_s = -.26$  to  $.52$ ) Normative beliefs for discussing were not correlated with either behavioural or control beliefs for discussing. Behavioural beliefs for discussing were the strongest correlate of intentions to discuss the decision ( $r = .52$ ). Intentions to register and discuss the donation decision were correlated at  $.32$ , suggesting that intentions to perform these behaviours were somewhat related.

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#### *Predicting Intentions to Register and Intentions to Discuss*

For each of the behaviours of registering and discussing, structural equation modelling was used to test the hypothesised relationships between intentions and the TPB belief variables and to determine the extent to which the TPB belief variables predicted intention. The separate sets of TPB belief predictor variables for each behaviour of registering and discussing were allowed to co-vary among themselves (i.e., registering behavioural, normative, and control beliefs were allowed to co-vary and discussing behavioural, normative, and control beliefs were allowed to co-vary). To examine the relationship between the two communication behaviours, the error residuals for the outcome measures of registering intentions and discussing intentions were also allowed to co-vary. This initial model was not a good fit to the data ( $\chi^2(15) = 41.57, p < .001$ , CFI =  $.83$ , TLI =  $.68$ , IFI =  $.84$ , RMSEA =  $.13$ ) and modification indices suggested the model would be improved significantly with the inclusion of a path allowing normative beliefs for registering and normative beliefs for discussing to co-vary. Thus, the model was re-analysed

with the inclusion of this additional path. The analysis for this final model indicated that behavioural, normative and control beliefs for registering had direct effects on intention to register, and behavioural and normative beliefs for discussing had direct effects on intentions to discuss (there was a non-significant path from control beliefs for discussing and intention to discuss; see Figure 1). The significant path between the outcome measures of registering intentions and discussing intentions confirmed that the two communication behaviours were related. The final model was an adequate fit to the data ( $\chi^2(14) = 28.10$ ,  $p = .01$ , CFI = .91, TLI = .82, IFI = .92, RMSEA = .10). Modification indices did not suggest any improvements to this model. All of the paths shown in the final model were significant at least at the  $p < .05$  level. The final model explained 33% of the variance in intentions to register ( $R^2 = .33$ ) and 30% of the variance in intentions to discuss ( $R^2 = .30$ ).

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### Discussion

Using a Theory of Planned Behaviour framework, we examined the important belief-based predictors of intentions to perform two communication behaviours crucial to the organ donation consent process, registering consent to donate organs upon death and discussing the organ donation decision with a partner or family members, in a sample of participants who had not previously communicated their donation decision. The results of the present study revealed that, across both behaviours, the advantages and disadvantages of communicating the donation

decision (behavioural beliefs) and perceptions of approval or social pressure from important referents to communicate the decision (normative beliefs) were the significant belief predictors of registering and discussing intentions. The influence of barriers preventing and motivators facilitating communication intentions, however, was less consistent. For both behaviours, the results offer support for the application of the belief basis of the TPB in the prediction of intentions to register and discuss the donation decision and provide several avenues for potential future intervention.

Behavioural beliefs comprising the advantages and disadvantages of performing each of the specific communication behaviours emerged as the most influential predictor (i.e., largest standardised regression weight) of both registering and discussing intentions. Disadvantages specific to each communication behaviour reflected those identified in previous research on communication of the decision (e.g., distress or conflict with family, discomfort talking about death, pressure to change the decision; Breitkopf, 2006; Radecki & Jaccard, 1997; 1999) and organ donation more generally (e.g., fear of premature death, lack of knowledge; Horton & Horton, 1991; Parisi & Katz, 1986) as well as raising some advantages (e.g., being aware of important others' decisions, gaining approval for the decision from family members) that have received less research attention. In line with the focus of many of the advantages and disadvantages concerning the impact of communication on important others, normative beliefs also emerged as a consistent influence across behaviours. Examination of the mean and standard deviation values of the normative beliefs for each of the behaviours revealed that participants were somewhat ambivalent about the approval or support of important referents for communicating their donation decision and these perceptions of approval varied widely. It is unclear whether this uncertainty reflects anticipated distress or discomfort as a result of discussing death or if it relates to potential conflict with family members due to their disapproval

of the concept of organ donation more generally. Alternatively, given that discussing the donation decision is a behaviour that is rarely performed (Breitkopf, 2006), the ambivalence about the approval of referents such as one's partner/spouse, family members, and friends for decision communication may simply reflect a lack of awareness about the organ donation preferences and beliefs of important others.

Given the consistent influence of the behavioural and normative beliefs sets for each behaviour, future interventions could focus on engaging participants in a cost-benefit analysis. This strategy could include acknowledging the potential disadvantages inherent in both communication behaviours (e.g., distress, conflict, discomfort) but promoting the idea that the benefits of communication far outweigh any costs as they assist in reducing future conflict or distress experienced by family members (e.g., making others aware of and gaining approval for the donation decision) and oneself (being aware of important others' donation decisions). Any such cost-benefit analysis may be facilitated by attempts to normalise discussion of the decision (e.g., via promotional strategies) and to encourage people to consider the behaviour as an accepted and valued practice (Waldrop et al., 2004).

In the current study, control beliefs (barriers and motivators) emerged as a significant predictor for registering intentions, but not intentions to discuss the donation decision; a finding that is in contrast to previous research identifying the importance of barriers to decision discussion (e.g., difficulty initiating a conversation) and the need for targeted interventions detailing how and when to start a conversation to promote decision communication (Morgan & Miller, 2002; McDonald et al., 2007; Waldrop et al., 2004). It may be that there are more salient barriers to decision discussion in the population examined in the current study than the elicitation study failed to tap into or it may be that participants in this population underestimate the potential difficulties of discussing their decision, including the spontaneous nature of the behaviour, the



dependence on interactions with other people, and the resources and opportunities required, given their lack of previous experience in communicating their donation decision.

Nevertheless, control beliefs significantly predicted registering intentions and comprised both barriers and motivators identified in previous research (e.g., the barriers of lack of knowledge about the process of organ donation, lack of knowledge about how to register, the motivators of knowledge about the process of organ donation and how to register; Hyde & White, 2007; Morgan, 2004). In addition, barriers (e.g., lack of motivation; being unsure about the donation decision) and motivators (e.g., the media, knowledge of the details of organ recipients) that have not been a primary focus of organ donation interventions were also identified (c.f. Singh, Katz, Beauchamp, & Hannon, 2002). Given that a lack of motivation and uncertainty about the donation decision have received little attention in previous research, the utility of employing strategies to address these specific beliefs should be investigated.

The formulation of specific plans detailing when, where and how an individual plans to communicate their decision (i.e., implementation intentions; Gollwitzer, 1999) may act as cues to behavioural performance and serve to motivate decision registration. It may also be beneficial to focus on identified motivators, including media exposure of the issue, given that media stories or advertisements can function to remind or prompt individuals to communicate their donation decision (Thompson et al., 2004; Vincent, 2006). The use of motivational stories in the media, combined with increasing knowledge about the process of organ donation and providing details about the types of people who need and receive organ transplants may also help to clarify organ donation decisions for those participants who are uncertain about their preference. Future research should continue to focus on identifying and understanding the barriers that prevent organ donation registration and discussion as well as the motivators that encourage performance of these important behaviours crucial to facilitating the consent process.

### *Conclusion*

In the recruitment of a sample of students and community members, this study provides a simultaneous examination and current depiction of the beliefs underlying the two communication behaviours of registering consent for organ donation and discussing the donation decision with significant others in a context where little research has been conducted. Utilising the belief-based theoretical framework of the TPB, the current study identified behavioural and normative beliefs as the two consistent predictors of registering and discussing intentions, and clarified that intentions to register and intentions to discuss are somewhat related.

In addition to identifying the common beliefs predicting intentions to perform these behaviours, the results also point to the potential value of a separate assessment of individuals who have not previously communicated their decision from those who have partially communicated their decision (i.e., those who may have registered their decision but not discussed it or vice versa) and the possibility that there are different belief sets underlying these sub-samples. Future research, then, should compare the belief predictors amongst people who have partially communicated their decision, as opposed to those without any history of communicating it, and could include further comparisons to those who have fully communicated their donation decision. The findings of the current research should be interpreted in light of the study's limitations, including the small sample size, the higher proportion of student, Caucasian and female participants, and the potential for higher numbers of individuals who felt positively about organ donation to self-select into the study.

Overall, the critical role of consent in the organ donation process, the concern about the consequences of communicating the donation decision (e.g., creating distress for family), and barriers (e.g., lack of motivation to register) preventing communication highlight the need to focus specifically on encouraging communication of the donation decision. This aim could be

achieved by the provision of strategies designed to reduce the perceived negative consequences of registering and discussing the decision. These potential strategies could include acknowledgement of the perceived difficulty of communicating the donation decision, as well as specific suggestions detailing how these difficulties could be overcome, and an emphasis on the benefits of communication. In addition to these strategies, having a prompt or motivator (e.g., media) to register the decision may facilitate the communication process. These strategies, in combination with a focus on the perceived approval of close referents (e.g., partner) for communicating the decision, may provide individuals with the motivation and confidence needed to register and discuss their organ donation wishes.

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#### Footnotes

1. Recruitment was directed primarily by the availability of participants such that, although we initially recruited six participants for each of the focus groups, if only some of these participants attended a given focus group, then we conducted the focus group with only those participants in attendance on the day (consequently focus group sizes varied from 3 to 6 participants).
2. While it is difficult to determine the full impact that a difference in the thank you gifts offered may have had on participation in the focus groups, the experience of participation was sufficiently similar for all participants. The thank you gift was provided for community participants as compensation for the costs of travelling to the venue where focus groups were held.
3. Although we have included reliabilities for the belief scales, according to TPB guidelines (Ajzen, 2006), it is not expected that the belief-based scales will be internally consistent given that an individual's endorsement of specific beliefs about a behaviour is likely to contain a degree of ambivalence such that some beliefs are valued positively and other beliefs are valued negatively. As a result, there is no expectation that beliefs will correlate highly with each other and internal consistency for belief scales are usually not reported.
4. Please note that the reason for the removal of the majority of cases was due to the absence of a response on the normative beliefs whereby participants could choose a value of zero if they did not have one or more of the normative referents listed (e.g., a partner).

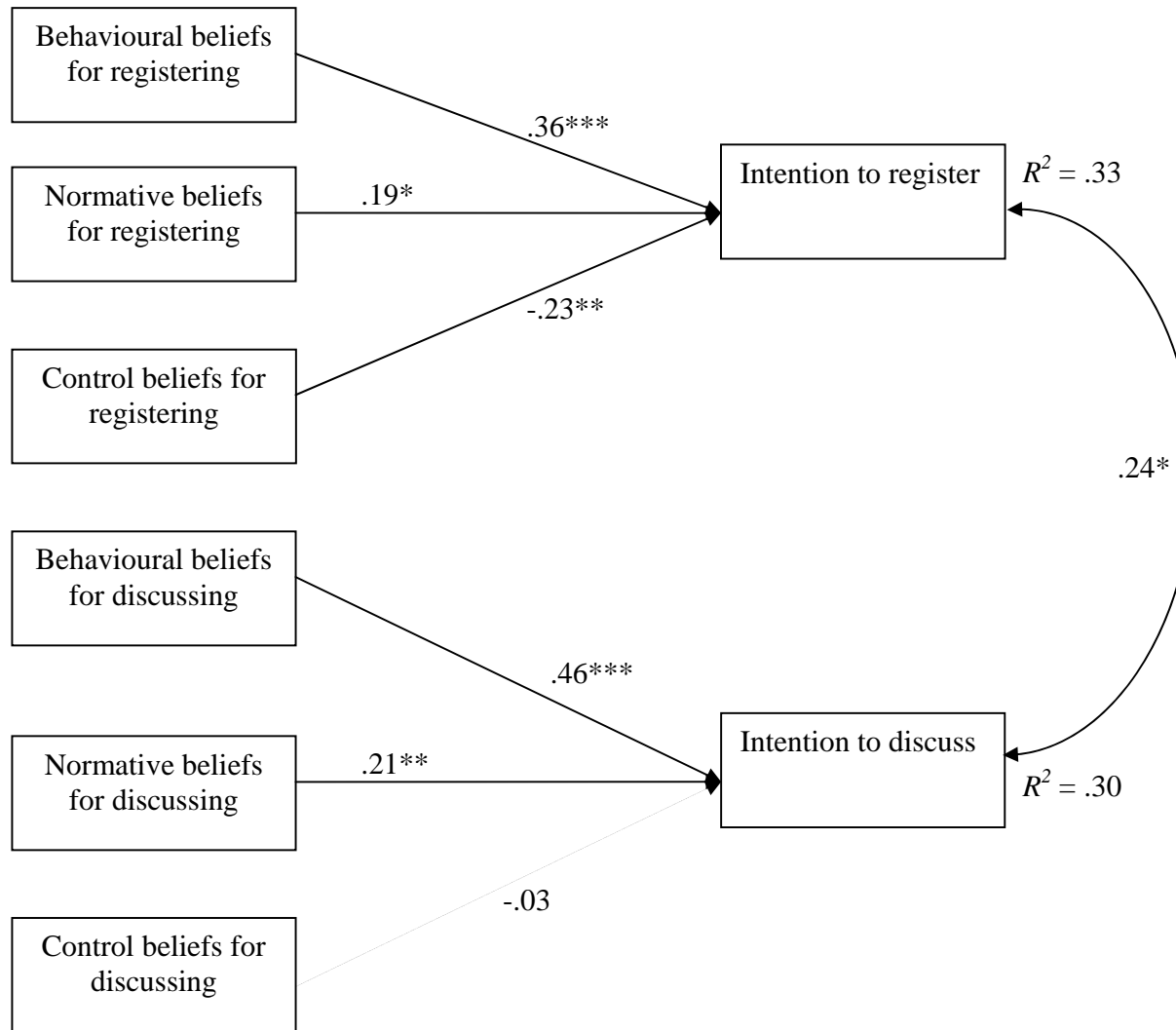


Figure 1. Final model fitted to the data for intentions to register and discuss the donation decision ( $N = 107$ )

\* $p < .05$ . \*\* $p < .01$ . \*\*\* $p < .001$ .

Table 1

*Bivariate Correlations, Means, and Standard Deviations for TPB Beliefs and Registering and Discussing Intentions*

Variable	1	2	3	4	5	6	7	8
1. Registering intention	-							
2. Registering behavioural beliefs	.49***	-						
3. Registering normative beliefs	.36***	.29**	-					
4. Registering control beliefs	-.42***	-.36***	-.20*	-				
5. Discussing intention	.32***	.17	.29**	-.22*	-			
6. Discussing behavioural beliefs	.21*	.29**	.23*	-.18	.52***	-		
7. Discussing normative beliefs	.04	.10	.38***	-.09	.28**	.17	-	
8. Discussing control beliefs	-.24*	-.30**	-.23*	.29**	-.26**	-.41***	-.15	-
<i>M</i>	4.37	4.30	4.22	4.08	4.86	4.55	4.28	4.01
<i>SD</i>	1.30	.73	1.00	.72	1.34	.83	1.29	.69

*Note.* \* $p < .05$ . \*\* $p < .01$ . \*\*\* $p < .001$ .